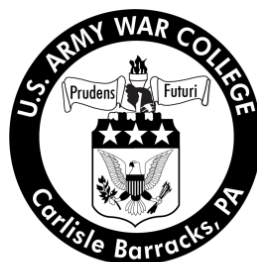


# Civilian Research Project Senior Service College Fellow

## The Army Selected Reserve Dental Readiness System (ASDRS): Historical Overview, Assessment and Recommendations

by

Colonel James R. Honey  
United States Army



United States Army War College  
Class of 2012

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by

Colonel James R. Honey  
United States Army

Mr. Thomas Libert  
Research Adviser

This CRP is submitted in partial fulfillment of the requirements of the Senior Service College fellowship.

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U.S. Army War College  
CARLISLE BARRACKS, PENNSYLVANIA 17013



## **ABSTRACT**

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The Army Selected Reserve Dental Readiness System (ASDRS) is a key dental program directed by the Assistant Secretary of the Army (Manpower & Reserve Affairs) starting in Fiscal Year (FY) 09. The Army National Guard and Army Reserve have steadily implemented ASDRS over the past three years as a means to improve the historically abysmal Dental Readiness of the Army Reserve Component (RC); Dental Readiness is essential for sustaining an Army RC Operational Force. ASDRS is a tool for RC commanders to provide contract Dental Readiness care in support of over 558 thousand non-mobilized Selected Reserve Citizen-Soldiers dispersed throughout the 54 states and U.S. territories, at home station before alert, and if necessary after alert (throughout the Army Force Generation cycle). This paper examines the status of ASDRS implementation, assesses its effectiveness in improving Army RC Dental Readiness, and provides Army leadership recommendations regarding the following focus areas: 1) Command emphasis; 2) Program execution; and 3) Synergy with the Military Health System (MHS) and Department of Veterans Affairs (DVA).





## THE ARMY SELECTED RESERVE DENTAL READINESS SYSTEM (ASDRS): HISTORICAL OVERVIEW, ASSESSMENT AND RECOMMENDATIONS

The committee believes that the ASDRS is a practical approach to ensure that the Selected Reserve meets current oral health requirements and is ready to deploy in a timely manner.

— Committee on Armed Services House of Representatives<sup>1</sup>

Dating back to the mobilization for Operation Desert Shield/Storm (1990-91), low Army Reserve Component (RC) Dental Readiness has been the subject of widespread concern.<sup>2</sup> At one time or another, this issue commanded the attention of the Secretary of the Army, the Assistant Secretary of Defense for Health Affairs, the Reserve Forces Policy Board, and the United States Congress. Although there were numerous senior leader and Congressional interventions over the years, Army RC Dental Readiness remained persistently low through Fiscal Year (FY) 08. The House Armed Services Committee (HASC) on Oversight and Investigations held a hearing on RC Dental Readiness in April 2008. In his opening statement, the Chairman, Vic Snyder (D-AR), discussed the challenges associated with achieving full Dental Readiness in the RC. He stated, "...the Army and Marine Corps have struggled the most." He went on to say, "The most important thing that they (service members) bring to the table is their health, the medical and dental readiness of the force." He concluded by saying, "Oral health is an often overlooked, but extremely important aspect of overall pre-deployment readiness."<sup>3</sup>

In April 2007 the Army, in an effort to increase Army Total Force capability, directed Army Initiative 4 (AI4) to operationalize the Army RC. One of the key goals of AI4 was to achieve a higher constant level of RC Soldier readiness.<sup>4</sup> Since low RC

Dental Readiness was a major obstacle preventing an increased constant level of Soldier readiness needed for AI4, the Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA (M&RA)) directed the establishment of ASDRS as a means to improve Dental Readiness in FY09.<sup>5</sup>

The Army National Guard (ARNG) and U.S. Army Reserve (USAR) have steadily implemented ASDRS over the past three years. ASDRS is a tool for RC Commanders to provide contract Dental Readiness care in support of over 558 thousand non-mobilized Selected Reserve Citizen-Soldiers dispersed throughout the 54 states and U.S. territories, at home station before alert, and if necessary after alert (throughout the Army Force Generation cycle).<sup>6</sup> ASDRS implementation is steadily progressing throughout the Army RC; however, the possibilities of improving ASDRS with better command emphasis, program execution, and synergy with the Military Health System (MHS) and Department of Veterans Affairs (DVA) could be groundbreaking.

#### Army RC Dental Readiness Importance and Historical Context

Dental Readiness is an important enabler for overall Department of Defense (DoD) Total Force Readiness. DoD requires the use of a dental classification system to quantify and track Dental Readiness (see Table 1).<sup>7</sup>

Table 1.<sup>8</sup>

<b><i>U.S. DoD Oral Health and Dental Readiness Classification (DRC) System</i></b>
<b><i>DRC 1:</i></b> Patients with a current dental examination who do not require dental treatment or reevaluation. DRC 1 patients are worldwide deployable.
<b><i>DRC 2:</i></b> Patients with a current dental examination who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. DRC 2 patients are worldwide deployable.
<b><i>DRC 3:</i></b> Patients who require urgent or emergent dental treatment. DRC 3 patients normally are not considered worldwide deployable.
<b><i>DRC 4:</i></b> Patients who require periodic dental examinations or patients with unknown dental classifications. DRC 4 patients normally are not considered worldwide deployable.

Dental emergencies have historically accounted for over 15% of all Disease and Non-Battle Injuries (DNBI).<sup>9</sup> Studies have shown that Service Members (SM) in DRC 3 have a 75% chance of becoming a DNBI within one year.<sup>10</sup> This can result in a unit losing a Soldier for days, or longer, severely degrading unit capability.<sup>11</sup> Additionally, deployed Soldiers with DNBI often require medical evacuation for treatment, potentially endangering themselves and others.<sup>12</sup> To avoid these preventable pitfalls, commanders must ensure DRC 3 Soldiers obtain corrective treatment in a timely manner (see Figure 1 for dental emergency rates).

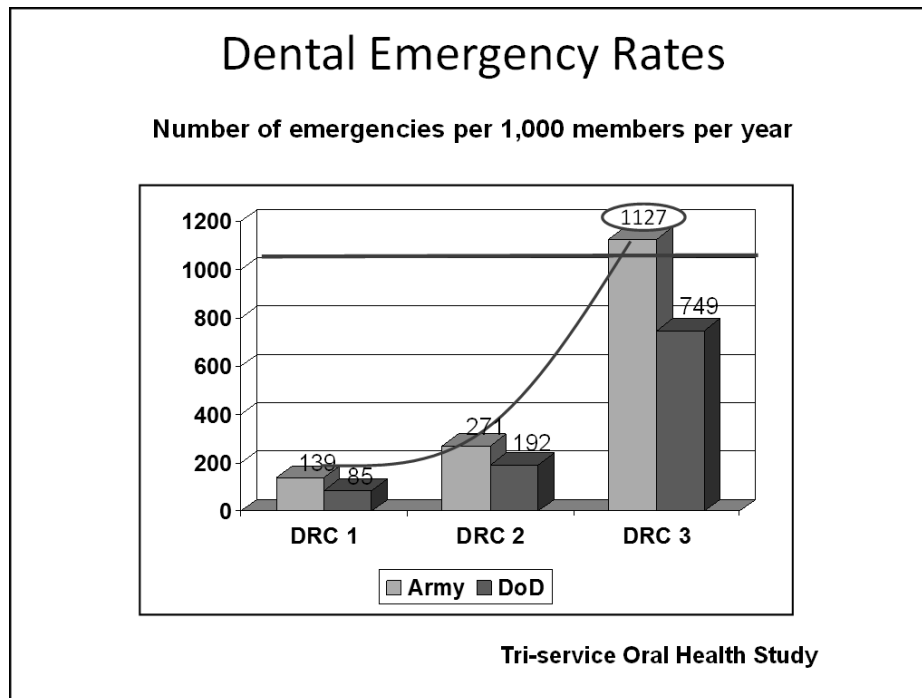


Figure 1.<sup>13</sup>

Unlike DRC 3, DRC 4 is a temporary administrative classification rather than a level of dental fitness. It is used to identify SMs who require a dental examination—either because they have not been previously examined and classified, or because they have not been examined for a lengthy period of time.<sup>14</sup> The DoD Total Force baseline—outside of alert—Dental Readiness standard is 95% (DRC 1 or 2).<sup>15</sup>

Dental Readiness is also one of the six Individual Medical Readiness (IMR) metrics that make up the DoD Fully Medically Ready (FMR) measure. The DoD Total Force FMR minimum goal is 75%.<sup>16</sup>

*The Dental Readiness Problem.* Throughout the mobilization process for Operation Desert Shield/Storm, many Army RC Soldiers spent long hours in the dental chair getting DRC 3 problems corrected.<sup>17</sup> Dental Clinics throughout the Active Army Dental Care System (AADCS) were running nearly continuous operations to support the

massive influx of newly mobilized RC Soldiers that needed Dental Readiness care (dental exams and DRC 3 treatments) on short notice.<sup>18</sup> Many RC Soldiers required complex dental therapies that involved multiple appointments and in some cases days to weeks of recovery—healing time.<sup>19</sup> If Soldiers could not be made ready to deploy in time, the RC cross-leveled (replaced) them by taking Soldiers from non-mobilized units, thus creating a domino effect of disrupted units in the wake of low Dental Readiness.<sup>20</sup> The compressed timeline limited dental provider treatment options, potentially reducing the quality of dental care. Numerous accounts from units showed that low RC Dental Readiness disrupted training and unit cohesion, increased stress on Soldiers, and reduced the time Soldiers could devote to properly addressing last minute personal and family matters.<sup>21</sup> In short, low Dental Readiness profoundly diminished the overall readiness and wellbeing of the Army RC.

From FY1990 through FY2008, Army RC baseline (outside of alert) Dental Readiness remained below 50%.<sup>22</sup> This occurred, in part, because unlike Active Duty (AD) Soldiers, RC Soldiers were not fully funded for Dental Readiness care unless they were alerted or were on orders for more than 30 days, in which case they had access to all the dental care normally available for AD Soldiers.<sup>23</sup> Since non-alerted RC Soldiers had to fund their own dental care—and perhaps did not fully understand their role or responsibility for maintaining readiness—many Soldiers neglected their dental health until after they were alerted.

Numerous actions employed by Congress, DoD, and the Army to increase Dental Readiness support had little impact.<sup>24</sup> The most challenging barriers to improving Dental Readiness stemmed from the very large (and geographically dispersed) Army

Selected Reserve population, coupled with an insufficient RC funding authorization outside of alert—this resulted in an ineffective tiered approach.<sup>25</sup> Because of these and other barriers, commanders could not hold Soldiers accountable for achieving Dental Readiness standards, resulting in perpetually low Dental Readiness. See Figure 2, highlighting the large Army Selected Reserve population (one of the most challenging barriers).

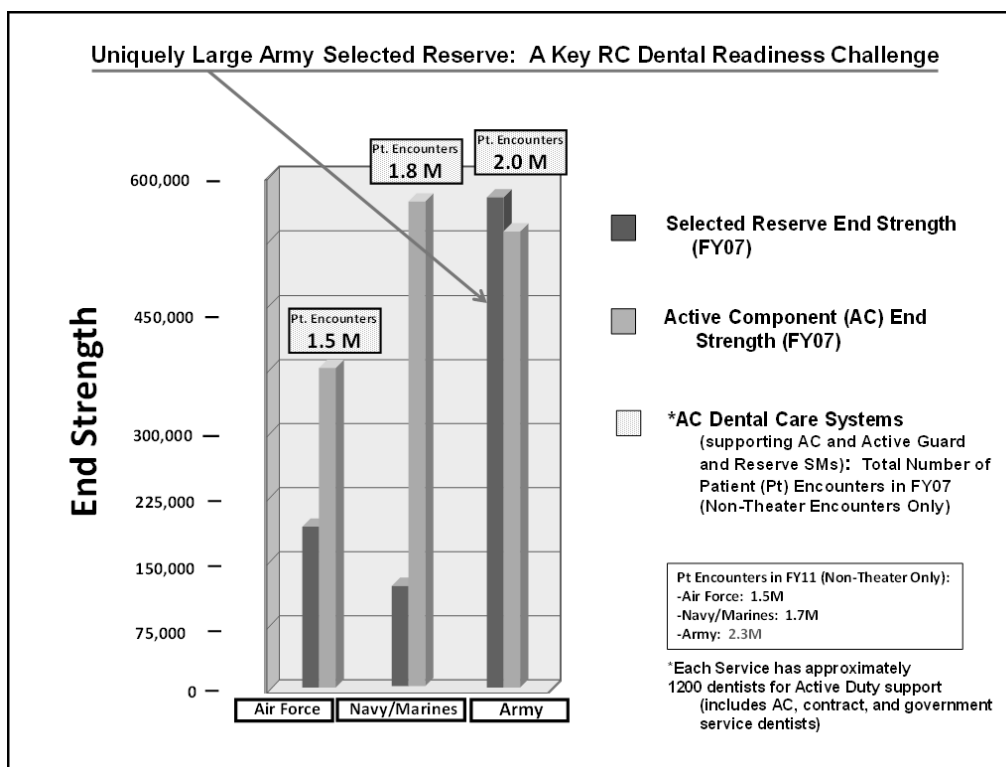


Figure 2.<sup>26</sup> The Army Selected Reserve population is nearly two times larger than the Air Force, Navy and Marine Selected Reserve populations combined.<sup>27</sup>

*Congressional and DoD Actions Taken.* Congressional and DoD actions to improve Dental Readiness are summarized in Table 2.

Table 2

***Congressional and DoD actions through FY07—In Response to Reports of Low RC Dental Readiness Following Operation Desert Shield/Storm (1990-91)***

*In 1954 (modified in 1993) Congress established the Department of Veterans Affairs (DVA) one time dental benefit: SMs may apply for VA dental care within 180 days of being Released From Active Duty (REFRAD)—benefits are subject to the requirements and limitations defined in Title 38 USC*

*In 1996, Congress established a premium-shared voluntary dental insurance plan for members of the Selected Reserve, the TRICARE Selected Reserve Dental Plan (TSRDP), and published Health Affairs (HA) policy 98-021, requiring RC SMs to have an annual dental examination*

*In 1998, HA, TRICARE Management Activity (TMA) and Reserve Affairs (RA) developed DD Form 2813, Reserve Forces Dental Examination, which enabled civilian dentists to report reservists' dental readiness status to their parent military organization*

*In early 2001, HA/TMA terminated the TSRDP and included the RC in a more comprehensive, affordable dental insurance program, the TRICARE Dental Program (TDP)*

*In 2001, Title 10, U.S. Code 1074(d) authorized RC members who have been issued a delayed-effective-date active duty order for a period of more than 30 days in support of a contingency operation to be treated as being on active duty for purposes of receiving medical and dental care*

*In 2001, Title 10, U.S. Code 1074a(d) authorized the Secretary of the Army (and later—2009, the Secretaries concerned) to provide members of the Selected Reserve who were designated "early deployers," any dental screening and care that is necessary to ensure the member meets the applicable dental standards for deployment (at no cost to the Soldier)*

*In 2001, DoD formed a Federal Strategic Health Alliance (FEDS\_HEAL) with the Departments of Veterans Affairs and U.S. Department of Health and Human Services, a contract entity providing limited dental services*

*In 2004, Title 10, U.S. Code 1074a(f) authorized the administering Secretary to provide members of the Ready Reserve who are to be called or ordered to active duty for a period of more than 30 days, any dental screening and care (purchasing FEDS\_HEAL services) that is necessary to ensure the member meets the applicable dental standards for deployment (at no cost to the SM)*

*In 2004, DoD established the Transitional Assistance Management Program, which provides SMs access to military DTFs for 180 days after REFRAD*

*In 2005, the DoD TMA initiated the Oral Health Initiative program administered through the Military Medical Support Office (MMSO) to provide DoD Service components Dental Treatment Facility (DTF) referred care for all eligible DoD SMs; this included all Active Guard and Reserve (AGR) SMs, and thus helped to increase AADCS capacity as more and more RC Soldiers were mobilized; in FY 09, TMA replaced the MMSO administered OHI program with the similar Active Duty Dental Program (ADDP)*

*DoD issued policies emphasizing Dental Readiness requirements and goals across the force, culminating in a 2006 DoD Instruction (DoDI) 6025.19 describing requirements for Individual Medical Readiness (IMR) and HA Policy 06-001 stating that the goal for baseline (outside of alert) total force DoD RC Dental Readiness standard is 95%*

Of the numerous Congressional and DoD actions listed in Table 2, four actions stood out as potentially having the most impact. First, in 2001 Congress enacted the partially government subsidized dental insurance program, the TRICARE Dental Program (TDP). This *voluntary* program had a low monthly premium (\$11.58/Soldier as of Feb 08) and provided two dental exams (and two cleanings) annually with no co-pay. Other procedures had co-pays of 20-50% (depending on the type of procedure and the SMs rank).<sup>28</sup> By 2008, only 8% of eligible Army Selected Reserve Soldiers had enrolled in the TDP, and only a small number of those that enrolled actually used their benefits to achieve Dental Readiness.<sup>29</sup> The TDP, therefore, had limited impact.

Second, in 2001 Congress authorized RC members who were issued a delayed-effective-date active duty order for a period of more than 30 days in support of a contingency operation to be treated as being on AD for purposes of receiving medical and dental care—“Early TRICARE.” But, many RC Soldiers resided far from military Dental Treatment Facilities (DTF), causing delays in obtaining Dental Readiness care. When Soldiers finally did obtain care, it often competed with pre-deployment training and sometimes resulted in failure to achieve Dental Readiness standards before deployment.<sup>30</sup>

Third, in 2001 DoD, DVA, and U.S. Department of Health and Human Services formed the Federal Strategic Health Alliance (FEDS\_HEAL) to make available contract Dental Readiness care. The Army RC used a limited funding authorization to program Operation & Maintenance (O&M) funds for purchasing FEDS\_HEAL services—outside of alert—for a small cohort of Selected Reserve Soldiers designated “early deployers” (at no cost to the Soldier). However, limited funding led to a tiered Dental Readiness



approach that made it difficult for the RC leadership to identify and track eligible Soldiers (“early deployers”). This caused reduced command emphasis, lowering the execution of funds and ultimately resulting in scarce resources that competed with other programs.<sup>31</sup> This approach led to poor results.

And finally, in 2004 Congress enacted the authority for DoD RCs to purchase Dental Readiness care for all alerted Ready Reserve SMs—at no cost to the SM.<sup>32</sup> The Army RC used this authority to purchase FEDS\_HEAL Dental Readiness care using contingency and/or O&M funds; however, there was frequently insufficient time between alert and mobilization to bring Soldiers up to Dental Readiness standards.<sup>33</sup> This “just in time” approach also disrupted pre-deployment training and other mobilization activities. Over half of RC Soldiers still typically reported to the federal mobilization platforms dentally unready.<sup>34</sup>

*Army Actions before ASDRS.* The Army employed numerous initiatives and programs to improve RC Dental Readiness. First, in 2004 the U.S. Army Dental Command (DENCOM) (that operates the AADCS) partnered with U.S. Army Training and Doctrine Command (TRADOC) to establish the First Term Dental Readiness (FTDR) program.<sup>35</sup> FTDR provided Dental Readiness care for all of the Army’s new recruits as they progressed through the 16 Advanced Initial Training (AIT) sites. This helped to increase the Dental Readiness of the approximately 65 thousand new Army RC recruits annually—affecting up to 10% of the Army RC end strength each year. Since FTDR affected a relatively small RC cohort, it had limited impact on baseline RC Dental Readiness.

In 2005 the Army RC working in conjunction with the Office of the Army Surgeon General (OTSG) helped to sponsor a Unified Legislative Budgeting (ULB) initiative (Health Affairs ULB 05-09A) designed to authorize and fund Dental Readiness care for all DoD Selected Reserve SMs regardless of alert status. The ULB failed due to “no” votes from the Navy, DoD Program Analysis and Evaluation, DoD Comptroller, and Assistant Secretary of Defense for Health Affairs.<sup>36</sup> The Under Secretary of Defense for Personnel and Readiness provided a failure summary in May 2007 stating that the proposal represented an expansion of existing benefits and lacked any cost offsets for transfer to the Defense Health Program (DHP). It went on to note that the proposal was duplicative of other initiatives designed to improve the Dental Readiness of the RCs.<sup>37</sup>

The Army also conducted various test initiatives and studies. There were two that were noteworthy. First, in 2007 the USAR conducted a Ready Response Reserve Unit (R3U) pilot. This pilot was to test the idea of using four Combat Service Support (CSS) units for non-traditional homeland support missions. As part of the R3U pilot, USAR leadership solicited RC dentists to volunteer for an extended mobilization (greater than 39 days, but less than 1 year) and assigned them to a small mobile dental unit.<sup>38</sup> The R3U dental unit was comprised of 8 volunteer dentists and accompanying ancillary; they would provide exams and limited Dental Readiness treatment in support of mobilizing USAR units. Because of the large USAR drilling Selected Reserve population and geographic dispersion, this approach would have only limited impact on baseline Dental Readiness. For example, OTSG estimated that it would take all 450 dentists assigned to the USAR (at that time) over a 2 month period, working a forty hour work week, to achieve the baseline DoD Dental Readiness standard (95%) within the

USAR. Additionally, the participating dentists would not be available to support other missions (based on the R3U volunteer service agreement). So, R3U could provide training and limited adjunctive dental support for alerted units, but it could not significantly impact USAR baseline Dental Readiness.<sup>39</sup>

Next, in 2006 and 2007, the Army reviewed options for providing a dental “reset” (bringing Soldiers to Dental Readiness standards) before RC Soldiers returned home from the Operation Iraqi Freedom (OIF) Theater. Planning estimates, however, revealed this to be impractical. For example, during that time, there were approximately 59 dentists serving in the OIF Theater to provide dental Combat Service Support (CSS) (in accordance with the doctrinal dental support Basis of Allocation for 120,000 SMs in Theater). So, in order to provide dental “reset” for a 2,000 person force departing Theater (with 1 day processing), it would require 59 dentists, 120 ancillaries, and 20 treatment rooms with 4 radiograph machines, running 3 shifts per 24-hour day to accomplish just the examinations (no other care provided). Dental “Reset” would, therefore, severely detract from the Theater CSS mission.<sup>40</sup>

DENCOM employed a modification of the “reset” approach in August 2008, called the Dental Demobilization Reset (DDR) program. This program provides Dental Readiness care for all demobilizing Soldiers at DDR garrison installations. Like FTDR, DDR supports a limited cohort (up to 10% of the Army RC per current deployment OPTEMPO).<sup>41</sup> Unlike FTDR, however, the size of the supported cohort is entirely dependent upon demobilization OPTEMPO.

*The RC Dental Readiness Problem Persisted.* At the onset of the Global War on Terror (GWOT) (2001), commanders relied heavily upon “just in time” Dental Readiness

care after alert, resulting in severely disrupted units across the RC force.<sup>42</sup> As a result of short timelines, some Soldiers could not be made ready to deploy and therefore had to once again be cross-leveled—replaced with a Soldier from a non-alerted unit.<sup>43</sup> Soldiers that were cross-leveled to a ready unit diluted that unit's readiness and lengthened training timelines.<sup>44</sup> In FY06, an estimated 9,500 ten-hour duty (training) days were lost at federal mobilization platforms as over 8,500 Selected Reserve Soldiers were provided “just in time” corrective dental treatment. In FY07, over 6,900 ten-hour training days were lost.<sup>45</sup> Even with intense late notice efforts in FY08, an estimated 7-15% of Soldiers still typically arrived at the federal mobilization platform in DRC 3 status.<sup>46</sup> Low Dental Readiness persisted as a major obstacle to achieving an Army RC Operational Force.

By FY08, it was apparent that stakeholder actions had not sufficiently increased baseline RC Dental Readiness (see Figure 3).

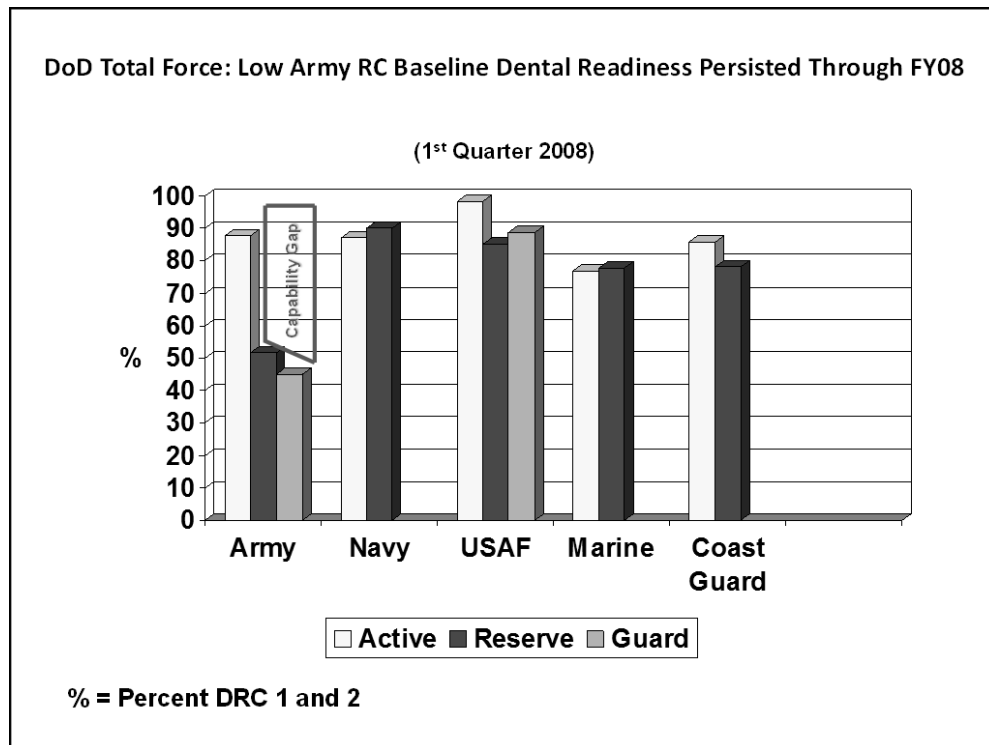


Figure 3.<sup>47</sup>

There were still numerous barriers impeding Army RC Dental Readiness improvement (see Figure 4).

## Summary: Barriers to Army RC Dental Readiness (as of FY08)



### **Large Population & Geographic**

**Dispersion:** Large population with limited organic dental resources. Dental Treatment Facility far from Soldier's home.



### **Funding:**

Lack of adequate funding authorization to provide Dental Readiness support outside of alert; resulted in tiered dental readiness approach.



Washington

**Command Emphasis:** Commanders had competing priorities and Dental Readiness historically had not been a top priority; without a viable Dental Readiness system, commanders could not hold Soldiers accountable.



### **Soldier Responsibility:**

Individuals often times did not understand their role or responsibility for maintaining their Dental Readiness; underutilization of available programs—enrollment in the TDP remained well below 10% and those that enrolled had low usage.



### **Information Management (IM):**

Non-existent interoperability; no dental data flow to and from the RC. Also, the use of the DD Form 2813 to annotate Dental Readiness care provided by civilian dentists was not well utilized.



### **Correcting Problems:**

Often times dental problems discovered during an exam were not corrected due to the Soldier's lack of civilian insurance or prohibitive cost shares or co-pays.



### **Time:**

With only 24 drill days and 14 days annual training, Dental Readiness competes with other training and readiness requirements.



### **Personnel:**

Authorized dental personnel based on war-time need; not sufficient to achieve and sustain RC Dental Readiness.

Figure 4.<sup>48</sup> The Army needed to address these barriers in order to improve RC Dental Readiness.

## Fiscal-Legal Framework for Establishing ASDRS

To successfully improve Army RC Dental Readiness, the RC needed a system sufficiently funded and capable of providing (and tracking) Dental Readiness support across the large, geographically dispersed RC force, regardless of alert status. The following three policy developments made such a system possible.<sup>49</sup>

First, in January 2007, the Secretary of Defense issued a policy that limited RC mobilizations to a maximum of twelve consecutive months.<sup>50</sup> This limitation increased predictability, relieving some of the stress that repeated mobilizations and deployments had on SMs. Units were mobilized, trained at mobilization stations, and then sent to theater where they spent twelve months supporting combatant commanders. Under this new policy the time units spent fulfilling remedial “just in time” requirements after mobilization reduced the amount of time the units could be conducting their mission.<sup>51</sup> This increased the impetus for the Service Secretaries to achieve a higher constant level of force readiness outside of mobilization and thus maximize the days units spent in theater conducting missions—to enable maximum Boots on the Ground (BOG) time.

Second, shortly after the Secretary of Defense issued his new mobilization policy, the Chief of Staff of the Army issued AI4 to operationalize the Army RC. A key AI4 task was for the Army RC to gain a higher constant level of Soldier readiness.<sup>52</sup> U.S. Army Forces Command tracked AI4 using the following four measures:

- Days of BOG time.
- Operational depth—the ability of the Army to reach back into the ready pool to satisfy spikes in operational demands for units.

- Strategic flexibility—the ability of the Army to rely more heavily upon the readiness of units within reset/train pool for homeland defense and unforeseen large-scale contingencies.
  - Unit stabilization to increase unit cohesion (including reduced cross-leveling).
- An increased constant Soldier readiness would improve these four measures.

Third, in December 2007, OTSG, the RC, and the ASA(M&RA) gained support—within Department of the Army (DA) and DoD—for increasing RC baseline Dental Readiness to improve the four AI4 measures.<sup>53</sup> So, the ASA(M&RA) issued a key policy in February 2008 that permitted a statute already in U.S. Code to require Dental Readiness funding for all non-alerted Selected Reserve Soldiers (at no cost to the Soldier).<sup>54</sup> This milestone policy effectively designated all Selected Reserve Soldiers as “early deployers,” and thus programmatically changed the DA G-1 Program Objective Memorandum (POM) strength drivers for the POM FY10-15. As a direct result of this policy, the POM strength drivers for ARNG and USAR O&M critical funding requirement for DRC 3 treatment increased from 95,000 to over 279,000 Soldiers and from 42,000 to over 176,000, respectively.<sup>55</sup> This increased the requirement for DRC 3 treatment by over 2.5 times (amounting to an additional Critical Requirement of over \$53M for the ARNG and over \$32M for the USAR for FY10—and an attendant Critical Requirement increase for the POM out-years).<sup>56</sup> *This was an important milestone, covering the Dental Readiness care for all Selected Reserve Soldiers outside of mobilization.*<sup>57</sup>



With funding mechanisms now in place to support both non-alerted and alerted Soldiers (at no cost to the Soldier), a Dental Readiness support system regardless of alert status—ASDRS—was now possible.<sup>58</sup> In July 2008, after working with DoD/DA stakeholders and the Dental All Army Working Group (DAAWG)—that included the ARNG Dental Surgeon, the USAR Command Dental Surgeon, the DENCOM Chief of RC Operations, and others—the OTSG dental staff officer, supporting Total Force issues, completed the staffing of recommended policy guidance for establishing ASDRS and forwarded it to ASA(M&RA) for final staffing.<sup>59</sup>

In September 2008, the ASA(M&RA) directed the Director of the ARNG and the Chief of the USAR to implement ASDRS in FY09 as a means to provide Dental Readiness care in support of all Selected Reserve Soldiers outside of mobilization, at home station before alert, and if necessary after alert (throughout the Army Force Generation cycle).<sup>60</sup> See Table 3 for a summary of the fiscal-legal framework used to establish ASDRS.

Table 3.<sup>61</sup>

## ***Summary: Fiscal-Legal Framework Used to Establish the Army Selected Reserve Dental Readiness System (ASDRS)***

1. Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA)(M&RA)) Policy Guidance Memorandum of 3 SEP 08, subject: Policy Guidance for Establishing the ASDRS, directs the Chief, Army Reserve and Director, Army National Guard to implement ASDRS and achieve the Dental Readiness standard (95%), prescribed in DOD Health Affairs (HA) Policy 06-001, in support of all Selected Reserve Soldiers outside of mobilization.

2. Description of Statutes/Policies used to Establish/Implement ASDRS.

a. Title 10, U.S. Code, Section 1074a (d), (1) and (2) states:

*"(1) The Secretary concerned shall provide to members of the Selected Reserve who are assigned to units scheduled for deployment within 75 days after mobilization the following medical and dental services:*

*...(C) An annual dental screening and (D) The dental care identified in an annual dental screening as required to ensure that a member meets the dental standards required for deployment in the event of mobilization...(2) The services provided under this subsection shall be provided at no cost to the member. "\*"*

b. ASA (M&RA) Policy Memorandum of 11 FEB 08, subject: Reserve Component Deployment Readiness Standards, states: "All Reserve Component (RC) Selected Reserve units of the Army are scheduled for deployment within 75 days after being mobilized."

c. Title 10, U.S. Code and Army Policy described at 2a and b establishes the statutory requirement for the Army to provide base program readiness funding for Dental Readiness care (limited to dental examinations and DRC 3 treatment) for all Selected Reserve Soldiers assigned to Selected Reserve units, outside of alert for mobilization.

d. The ASDRS Policy Guidance at 1 directs the Chief, Army Reserve and Director, Army National Guard to implement ASDRS using base program readiness funding (Operation and Maintenance funding) to achieve the HA Policy 06-001 Dental Readiness standard (95%) in support of all Selected Reserve Soldiers assigned to Selected Reserve units, outside of alert for mobilization.

e. Once alerted (and called or ordered to active duty for a period of more than 30 days), ASDRS may use contingency funds for alerted Ready Reserve Soldiers (Selected Reserve, Individual Ready Reserve, and Inactive National Guard) IAW Title 10, U.S. Code, Section 1074a (f) (1). ASDRS base program readiness funds should not be depleted when ASDRS contingency funds are authorized - after alert.

*\*Also, note: Title 10, U.S. Code 1074a(d) (D) applies to ASDRS (DENTAL) ONLY. MEDICAL would require enhanced legal authority to provide MEDICAL TREATMENT outside of alert.*

## ASDRS Development and Implementation

Beginning in June 2007, OTSG worked in collaboration with DoD/DA stakeholders and the DAAWG to develop ASDRS; the initial focus included ensuring electronic dental tracking across the continuum of Army care.<sup>62</sup> First, in order for all three Army components to share digital images, the AADCS (operated by DENCOM) implemented the Army Dental Digital Repository (ADDR). Second, the USAR adopted DENCLASS, which is a dental recording-tracking software that the ARNG was already using.<sup>63</sup> Finally, stakeholders worked to make DENCLASS more interoperable with the Corporate Dental Application (CDA), which is a dental recording-tracking (and scheduling) software developed and used by the AADCS.<sup>64</sup>

As a separate but related interoperability issue, CDA is also used by the Air Force and was recently accepted by the Navy, which will make it the sole dental software application used within the MHS.<sup>65</sup> Outside of the MHS, however, the DVA uses the Veterans Health Information Systems and Technology Architecture (Vista) dental application that is not interoperable with CDA.<sup>66</sup> So, MHS/DVA stakeholders are working to develop a single Integrated Electronic Health Record (iEHR) solution that will include a dental application.<sup>67</sup> But, because iEHR development and implementation will likely take a considerable amount of time, electronic dental information will, therefore, remain non-transferable between the DVA and the MHS for the foreseeable future.


The Tri-Service Reserve Health Readiness Program (RHRP) is one of the contract vehicles employed by ASDRS to provide Dental Readiness care. The RHRP Statement of Work (SOW) is aligned to help automate and streamline ASDRS processes.<sup>68</sup> It requires the contractor to electronically upload DENCLASS and use an Automated Voucher System (AVS) to schedule either in-office dental appointments or

“mass events.”<sup>69</sup> ASDRS tracks Dental Readiness using DENCLASS and the ADDR, which automatically updates the Army tracking tool, Medical Protection System (MEDPROS).<sup>70</sup> The RHRP SOW requires that the contractor provide the ASDRS administrative support services listed on Table 4.

Table 4.

<b><i>Reserve Health Readiness Program (DoD Contract Vehicle): Statement of Work For ASDRS Administrative Support Services</i></b>
<i>-Appoint Soldiers for in-office appointments with a dental provider within 50 miles of their home station or place of employment (approximately 6,000 dental providers positioned to ensure 50 mile proximity in support of all Army Selected Reserve Soldiers outside of mobilization).</i>
<i>-Remind Soldiers of appointments via phone calls and emails—three attempts are made to all phone numbers on file in addition to sending an email and postcard.</i>
<i>-Ensure radiographs and dental tracking records are either captured as, or converted to, a digital format.</i>
<i>-Ensure upload of the DENCLASS and ADDR, providing accessibility to documented digital Dental Readiness compliance for follow-up dental appointments and federal mobilization platform readiness validation.</i>
<i>-Provide support for dental “mass events” if needed. Units can schedule mass events as a last resort, as one of the goals of the ASDRS policy is to facilitate “dental home” at home station Standard Operating Procedures that enables repeat in-office appointments with the same dental provider.</i>
<i>-Work with the Army RC to ensure an effective Quality Assurance (QA) plan is implemented.</i>

The USAR decided to employ RHRP exclusively as the ASDRS contract vehicle. The ARNG employs RHRP as well as other local contractors. See Figure 5 showing a USAR web poster that explains Dental Readiness and ASDRS to commanders and Soldiers (the ARNG disseminated a similar message).



# ATTENTION AR SOLDIERS!

**FREE DENTAL CARE** is now available for Class 3 and 4 Conditions!


Class 1 or 2 AR Soldiers, don't become a Class 4. Maintain your readiness by getting a **FREE** annual exam. See your Unit Administrator today, or call 1-800-666-2833 for an appointment.

**CLASS 1**  
**FREE EXAM**  
IF 10 MONTHS SINCE LAST

**CLASS 2**  
**FREE EXAM**  
IF 10 MONTHS SINCE LAST

**CLASS 3**  
**FREE DENTAL TREATMENT**


**CLASS 4**  
**FREE DENTAL EXAM**



✓

**DEPLOYABLE**

**DENTAL READY = MISSION READY**



✗

**DEPLOYABLE**

**HOW DO I GET MY FREE DENTAL CARE?**  
 Pick up your phone and call your Unit Administrator (UA), or call 1-800-666-2833 to get the ball rolling. Go to the U.S. Army Reserve Command Surgeon web page at [www.us.army.mil/suite/page/51950](http://www.us.army.mil/suite/page/51950), for more information.

**How is dental readiness determined and why is it important?**

The dental fitness classification is the primary measure of a Soldier's dental readiness. The commander can use the dental fitness classification of unit personnel as an index of dental preparedness and to identify individuals who will require treatment during mobilization. The Army Selected Reserve Dental Readiness System (ASDRS) provides dental treatment for Class 3 AR Soldiers, and annual exams for ALL AR Soldiers outside of mobilization. The DOD Dental Classification Guideline and AR 40-35 outline the following dental fitness classifications:

**Standardized Dental Fitness Classifications\***

**Class 1:** Worldwide Deployment with no further treatment required.

**Class 2:** Worldwide Deployment with need for non-urgent routine treatment.

**Class 3:** Nondeployable without treatment for urgent conditions that likely will cause a dental emergency within 12 months.

**Class 4:** Nondeployable with no examination documented within the past 12 months.

\*A Synopsis of Reference: DoD Health Affairs: Policy 02-011 on the Standardization of Oral Health and Readiness Classifications, 4 June 2004

Figure 5.<sup>71</sup> USAR poster explaining Dental Readiness and ASDRS to commanders and Soldiers.

ASDRS uses base program funding (O&M) for non-alerted Soldiers. As earlier noted, the Army included ASDRS as a Critical Requirement within POM FY10-15, and later in POM FY12-17.<sup>72</sup> After alert, ASDRS can use contingency funding for alerted Ready Reserve Soldiers.<sup>73</sup> Using contingency funds after alert helps to avoid depleting base program funding for non-alerted Soldiers.<sup>74</sup>

Once a Soldier reports to the federal mobilization platform, they are no longer eligible for ASDRS Dental Readiness care; the AADCS provides remedial Dental Readiness care for mobilized Soldiers.<sup>75</sup> Since ASDRS implementation, the need for “just in time” remedial Dental Readiness care at federal mobilization platforms has steadily declined, as more Soldiers now arrive dentally ready to deploy.

#### ASDRS Implementation Assessment and Discussion

ASDRS implementation has thus far led to significant Dental Readiness improvements. Army RC baseline Dental Readiness has increased from 50% to an unprecedented 81%; for Soldiers arriving at the federal mobilization platforms, Dental Readiness has increased from 45-60% to over 93%.<sup>76</sup> This is an extraordinary 31 and 33 percentage point increase, respectively. Moreover, the achievement of 81% baseline Dental Readiness is the single largest IMR metric increase since FY08, helping to boost FMR to a historic 72% (up from 26%). These Dental Readiness gains have not only improved FMR and reduced mobilization costs, but they have also saved training days, reduced cross-leveling, and maximized BOG time—trends signifying an enhanced Operational Force (See Figure 6).<sup>77</sup>



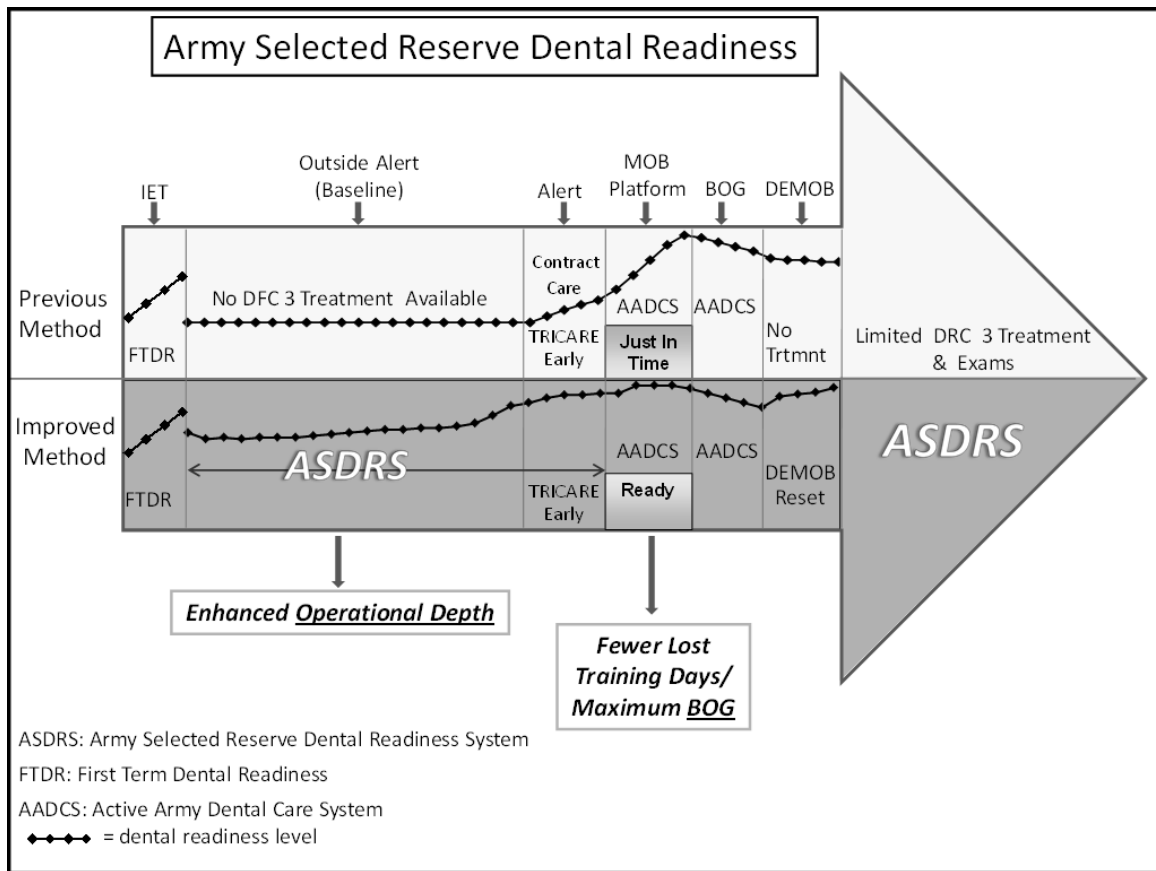


Figure 7. ASDRS Impact: The bottom half of the “arrow,” illustrates the positive impact that ASDRS has had on baseline Dental Readiness (going from 50% to 81%); for Soldiers arriving at the federal mobilization platforms, ASDRS has helped to boost Dental Readiness levels to over 93% (compared to 45-60% before ASDRS).

ASDRS implementation has continued to gain effectiveness over the last 3 years; however, its full potential may not yet be realized. Even though the increase in baseline Dental Readiness to 81% is a vast improvement, it remains well below the DoD 95% Dental Readiness standard.<sup>83</sup> Likewise, 7% of Soldiers still arrive at federal mobilization platforms requiring some type of dental follow-up (the goal is to arrive fully ready). Finally, the DRC 3 rate upon examination (outside of alert) is currently over 21%. Although this rate is down from 27% in FY08, it should further decline as ASDRS is able to more consistently provide follow-up treatment for DRC 3 Soldiers over time.<sup>84</sup>



Command emphasis is an area that requires improvement. As with any large scale implementation, achieving command emphasis as capabilities increase is a challenging process that takes time. To date, there are still commanders, Soldiers and Unit Administrators (UA) in the field that are not fully aware of ASDRS capabilities and processes.<sup>85</sup> Also, the DRC 4—indeterminate—population remains relatively high, at over 11%. A realistic short-term goal is to bring the DRC 4 percentage down to that of the Physical Health Assessment (PHA) indeterminate level or below—PHA indeterminate level is currently at 8%.<sup>86</sup> So, the relatively high percentage of DRC 4s, ASDRS awareness gaps, along with an over 18% no show rate for contracted RHRP “mass events,” underscores that command emphasis is not yet sufficient.<sup>87</sup>

Mobilization (M)-Day and Troop Program Unit (TPU) commanders are responsible for providing command emphasis at the unit level. They can accomplish this by either directing leaders to assist Soldiers with scheduling *in-office* dental appointments or through scheduling “mass events” for collective unit follow-up (USAR Soldiers can also call RHRP directly to schedule appointments). Both methods help to drive execution; however, promoting mostly in-office appointments instead of “mass events” is an ASDRS policy goal and has numerous important advantages.<sup>88</sup> First, using in-office appointments allows the attending dentist to have better access to their office staff, equipment, and records, and thus promotes greater QA, continuity of care, and an enhanced patient care experience. Second, scheduling in-office exams potentially reduces duplicated services—since it is less likely that an in-office exam performed in the same office as the follow-up treatment will need to be redone. And finally, using in-office appointments helps to establish a dental office familiar to the

Soldier in case they need to return to the office for post-operative follow-up care.

Currently, less than 50% of ASDRS patient encounters are accomplished via in-office appointments.<sup>89</sup> So, commanders should increase the use of in-office appointments—as directed per ASDRS policy guidance—to promote greater QA, an enhanced patient care experience, and to reduce duplicated services.<sup>90</sup>

Next, to enforce ASDRS execution, commanders must have the ability to address remaining barriers. AD Soldiers do not take unpaid leave to go to the dentist, nor should drilling RC Soldiers.<sup>91</sup> The USAR, therefore, is implementing a paid medical-dental readiness days program to put Soldiers on orders to attend in-office dental appointments. This program provides an incentive for the Soldiers to complete Dental Readiness requirements and provides a tool for commanders to enforce compliance.<sup>92</sup> This will further improve overall unit readiness by removing Dental Readiness as a competitor for training days. The ARNG has not yet implemented a similar program, although they have increased the number of available Inactive Duty Training (IDT) days that could be used for dental. These additional IDT days, however, are not specifically designated for dental, and, therefore, commanders may not decide to use them to enforce Dental Readiness compliance.<sup>93</sup>

Finally, there is a need for improved electronic interoperability with the MHS and DVA Information Management (IM) systems. ASDRS has only partial interoperability with CDA and none with the DVA VistA dental application. Overall, there are four primary interoperability gaps impeding data transfer within the federal continuum of dental care (see Table 5).

Table 5.

<i><b>Primary Interoperability Gaps</b></i>
<i>1. Lack of electronic exam and treatment information transfer from the AADCS to ASDRS (DENCLASS)—this is most problematic for Soldiers transferring from FTDR sites back to their RC units.</i>
<i>2. Treatment information generated by AADCS private sector referrals—using ADDP*—is not uploaded into CDA/ADDR, or DENCLASS, causing loss of treatment information.</i>
<i>3. Without an MHS IM dental enterprise solution, there is no ability to modify ADDP SOW to require that dental treatment information be uploaded into a single IM system.</i>
<i>4. The DVA and MHS cannot share any electronic dental information.</i>
<i>*All three MHS Service Components use the Tri-service ADDP private sector referral system.</i>

### Command Emphasis: A Remaining Key Challenge

Command emphasis is the single largest remaining barrier to achieving the baseline (outside of alert) Dental Readiness standard (95%). ASDRS now makes it possible to hold commanders and Soldiers accountable for achieving Dental Readiness—the resources are in place. Below are background items and policy incentives discussing command emphasis:

- In November 2008, the Secretary of Defense provided Commission on the National Guard and Reserve (CNGR) Implementation Plans directing the Secretaries of the Military Departments to aggressively enforce: 1) Establishment of additional duty days required of the members to receive dental exams and DRC 3 treatment.<sup>94</sup> 2) Add accountability for unit readiness and performance of ARNG and USAR units into the duty description of commanders of those units. 3) Review officer performance

appraisal system to determine if the system adequately provides for readiness accountability or if the system should be modified to provide for such accountability.<sup>95</sup>

- The April 2011 Secretary of Defense Report to the Services (Subject: Report on the Comprehensive Review of the Future Role of the Reserve Component) emphasizes the importance of achieving Medical Readiness and highlights the lack of incentives for RC SMs to achieve Medical Readiness; it recommends:

Assessing medical readiness for Reserve Component service members within 6 months of the time they complete their annual training requirements and taking appropriate corrective actions to enable affected units to reach current DoD standards.<sup>96</sup>

- Army Regulation (AR) 40-501 specifies under the USAR section that Soldiers maintain their Dental Readiness, and it specifies under the ARNG section that commanders must ensure Soldiers meet Dental Readiness requirements prior to attendance of Annual Training (AT).<sup>97</sup>
- The March 2010 ASA(M&RA) report to the Under Secretary of the Army and Vice Chief of Staff of the Army (Subject: Transforming the Army's Reserve Components into an Operational Force) recommends enforcement of Dental Readiness standards by increasing command emphasis on ASDRS. It states:

...aggressively use the newly established ASDRS to achieve the DoD Dental Readiness standard (95%) in support of the overall DoD Medical Readiness minimum standard (75%).<sup>98</sup>

- The April 2011 HQDA Execute Order 185-11, (Subject: Reduction of Non-deployables) requires the Army to review and refine policies, processes, and

systems; provide relevant training and apply command emphasis in order to reduce the Medical Non-deployable rate to 10 percent or less no later than April 2012.<sup>99</sup>

- The May 2011 U.S. Army Medical Command Soldier Medical Readiness Campaign Plan discusses the implementation of a single source Army Dental Readiness Information Center (DRIC) using the Army Knowledge Online (AKO) portal. The DRIC contains component specific guidance and documents for ARNG and USAR commanders and Soldiers describing how to use ASDRS and achieve Dental Readiness standards (it also informs Soldiers on how to use the DD Form 2813 to document Dental Readiness compliance if undergoing care through a private dentist).<sup>100</sup> The goal is for the Army RC to use the DRIC to update documents and guidance on a real-time basis to minimize confusion for RC commanders and Soldiers.
- The “My Dental” link, also on the AKO homepage, provides: 1) Information on Oral Health and Disease Prevention—to include topics on home care fluoride, hygiene, diet, and xylitol gum; and the benefits of obtaining dental sealants. 2) Information on how to sign up for the TDP insurance program to achieve maximum dental health (the current Army RC TDP enrollment rate is less than 10%).<sup>101</sup>
- The October 2009 Deputy Assistant Secretary of Defense report to Congress (Subject: Enhancement of Medical and Dental Readiness of Members of the Armed Forces) highlights that the Air National Guard, Air Force Reserve, and Navy Reserve have implemented a policy of not issuing AT orders unless the

SM meets medical readiness requirements. The ARNG and USAR have not yet implemented a similar policy.<sup>102</sup>

- In 2011, the U. S. Army Reserve Command Office of the Staff Judge Advocate (SJA) highlighted possible responses to Dental Readiness non-compliance (with the caveat that the responses should be coordinated with the SJA and based on written orders): 1) “Unexcused absence” due to unsatisfactory participation. 2) Bars to reenlistment. 3) Administrative separation for misconduct or unsatisfactory participation. 4) Article 15 for failure to obey a lawful order.<sup>103</sup>

*Unit Status Report (USR) Change.* In 2009, the Army decided to change the AR 220-1 (Army Unit Status Reporting) so that Soldiers classified as Medical Readiness (MR) 4—which includes Soldiers that are DRC 4 and/or lack a current PHA—are no longer counted on USR readiness assessments.<sup>104</sup> This change to USR reporting, therefore, reduces leader awareness of DRC 4s and may reduce command emphasis for examining DRC 4s.

Leader awareness of DRC 4s is important. Recent exam data shows that over 21% of Army Selected Reserve Soldiers classified as DRC 4 (outside of alert) are classified as DRC 3 when examined; therefore, a significant number of DRC 3 Soldiers are masked within the DRC 4 Soldier population.<sup>105</sup> So, commanders need to ensure that DRC 4 Soldiers obtain an examination and corrective DRC 3 treatment.

In August 2009, the Office of the Assistant Secretary of Defense issued a memorandum to the Army that recommended that the Army keep MR4 in USR readiness assessments; it stated:

The USR is a critical tool necessary to ensure ASDRS command emphasis and execution by holding commanders accountable for achieving increased dental and medical readiness. ASDRS command emphasis at national, state/region, and unit level is needed to increase dental readiness through awareness, leader interaction, and resource management. Reporting dental readiness will keep this issue transparent and consistent among the COMPOS. We therefore recommend the Army reconsider removing MR 4 from the USR.<sup>106</sup>

Notwithstanding, the Army removed MR4 from USR readiness assessments—by designating MR4 as “available for deployment” instead of “non-available for deployment” per April 2010 AR 220-1 update.<sup>107</sup>

### Recommendations

*Command Emphasis.* 1) Leverage the new Dental Readiness Information Center (DRIC) on the AKO homepage. The DRIC contains guidance for commanders and Soldiers describing how to utilize ASDRS.<sup>108</sup> Leadership can use the DRIC to update ASDRS information in real-time to minimize confusion for commanders and Soldiers. 2) Establish an Army policy that requires Selected Reserve Soldiers to meet the AR 40-501 Dental Readiness standard (DRC 1 or 2) in order to be issued AT orders.”<sup>109</sup> This will definitively increase command emphasis. 3) Count MR4 on USR readiness assessments. This will ensure that USR readiness assessments accurately quantify Dental Readiness.

*ASDRS Execution.* 1) Implement an ARNG paid medical-dental readiness days program and continue to improve the USAR paid medical-dental readiness days program.<sup>110</sup> 2) Prioritize scheduling of *in-office* dental appointments rather than using “mass events”—for both exams and DRC 3 treatments.<sup>111</sup>

*Synergy with the MHS and DVA.* 1) Build upon CDA and ADDR to implement a single electronic MHS IM dental enterprise solution coupled with a Federal Dental

Digital Repository that stores all federal dental radiographic information.<sup>112</sup> In the interim, ensure that the AADCS transfers FTDR electronic exam and treatment information to ASDRS (DENCLASS-ADDR) in support of Soldiers transferring back to the RC. 2) Modify ADDP Statement of Work to require electronic upload into the new MHS IM dental enterprise solution.<sup>113</sup> 3) Integrate the DVA VistA dental application with the MHS dental enterprise solution for continuity of care throughout the federal continuum of care—as an incremental step towards the iEHR.<sup>114</sup>

### Conclusion

ASDRS has helped to boost Army RC baseline Dental Readiness 31 percentage points to an unprecedented 81%—which has also helped to lift Fully Medically Ready (FMR) from 26% to a historic high of 72%. This is a significant achievement when considering the longstanding persistence of low Army RC Dental Readiness and the disappointing outcomes of numerous earlier initiatives. There are, however, additional opportunities for improving ASDRS command emphasis, program execution, and synergy with the MHS and DVA. Three focus areas stand out as potentially having the greatest impact on this. First, requiring Dental Readiness compliance in order for Soldiers to be issued AT orders, plus counting MR4 on USR readiness assessments, would definitively sustain a culture of Dental Readiness compliance and would further drive the ASDRS refinement process. Second, ensuring that both Army RC components have a robust paid medical-dental readiness days program, coupled with leveraging these programs to prioritize in-office appointments instead of “mass events,” would promote increased QA, an enhanced patient care experience, and a reduction of duplicated services. Third, establishment of an MHS IM dental enterprise solution and



integrating it with the DVA VistA dental application would open a path for improved federal continuity of care—while also advancing the iEHR development process.<sup>115</sup>

These actions, if taken, would serve as a catalyst for continued ASDRS refinement and encourage stakeholders to further collaborate with the MHS and DVA, not only to improve ASDRS, but to improve continuity of dental care throughout the federal continuum of care. This would have a positive impact on quality assurance, readiness, and cost (by reducing duplicated services). Improvements in Dental Readiness within the ARNG and the USAR will improve the readiness of the U.S. Army. Not only will this help the nation operationally with cost-savings in preventing expensive duplicated dental services, but it will also improve the quality of life for Citizen-Soldiers and support the United States' vital interests strategically with a more combat-ready and rapidly deployable Army.

## Endnotes

<sup>1</sup> Selected Reserve definition: Those units and individuals within the Ready Reserve designated by their respective Services and approved by the Joint Chiefs of Staff as so essential to initial wartime missions that they have priority over all other Reserves (IAW Title 10, U.S. Code 10143). Duncan Hunter National Defense Authorization Act for Fiscal Year (FY) 2009, 110th Cong., 2nd sess. H. Rept. 110-652 (Washington: GPO, May 16, 2008), Reserve Component Dental Readiness, 384.

<sup>2</sup> Even before Desert Shield/Storm, there was mounting evidence that low Army RC Dental Readiness was cause for concern—"In 1985, the Army Dental Corps conducted a study which analyzed the dental health of 7,512 Reserves and National Guard soldiers. Results of the study (published in 1986) demonstrated an overall Class 3 rating (non-deployable) of 29 percent for Reserve Component personnel. The distribution of Class 3 soldiers was predictive of that seen during mobilization for Desert Shield/Storm." Gary W. Allen, *Dental Health in the Army Reserves and National Guard: A Mobilization Problem?* (Fort McNair, Washington, DC: The Industrial College for the Armed Forces, April 1992), 1-3 and 5.

<sup>3</sup> Vic Snyder, (D-Ark), U.S. Congress, House of Representatives, House Armed Services Subcommittee, Opening Statement: *Challenges Associated with Achieving Full Dental Readiness in The Reserve Component*, Hearings before the Subcommittee on Oversight and Investigations in Support of the Military Personnel, 110th Cong., 2nd sess., April 23, 2008, 3-4.

<sup>4</sup> U.S. Army Center for Army Analysis, *Cost Benefit Analysis of Army Initiative 4-Reserve Component as an Operation Force* (Fort Belvoir, VA: U.S. Army Center for Army Analysis, February 2008): 7.

<sup>5</sup> U.S. Department of the Army, Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA (M&RA)) Ronald J. James, "Policy Guidance for Establishing the Army Selected Reserve Dental Readiness System (ASDRS)," memorandum for Chief, Army Reserve and Director, Army National Guard, Washington, DC, September 3, 2008.

<sup>6</sup> Ibid.

<sup>7</sup> U.S. Department of Defense (DoD), Under Secretary of Defense (Personnel and Readiness) David S. C. Chu, *Individual Medical Readiness (IMR)*, DoD Instruction (DoDI) 6025.19 Washington DC, January 3, 2006, E4; U.S. DoD: Health Affairs Policy 98-021: Policy on Uniformity of Dental Classification System, Frequency of Periodic Dental Examinations, Active Duty Overseas Screening, and Dental Deployment Standards (Washington, DC, DoD, February 19, 1998): 1.

<sup>8</sup> The DoD Classification Chart was adapted from the Military Medicine article: Jeffrey Chaffin and David Moss, "Review of Current U.S. Army Dental Emergency Rates" *Military Medicine* Vol. 173, January Supplement (2008): 24.

<sup>9</sup> U.S. DoD, Office of the Assistant Secretary of Defense For Reserve Affairs and Office of the Assistant Secretary of Defense for Health Affairs, *Means of Improving the Provision of Uniform and Consistent Medical and Dental Care to Members of the Reserve Components*, report to Congress as required by Section 746 of the National Defense Authorization Act for FY 997 (Washington, DC: U.S. DoD, August 1997), 16. [www.dod.mil/pubs/Sec746\\_111099.html](http://www.dod.mil/pubs/Sec746_111099.html) (accessed January 15, 2012); Mark B. Bodenheimer, "Army Reserve Components Dental Readiness—A Historical Review Since the First Gulf War," *U.S. Army Medical Department Journal* PB 8-06-1/2/3, no. Jan/Feb/Mar (2006): 27.

<sup>10</sup> Andrew K. York and David L. Moss, "A Longitudinal Study of Dental Experience during the First Four Year of Military Experience," *Military Medicine* Vol. 173, January Supplement (2008): 38-41.

<sup>11</sup> David Sproat, ARNG Surgeon, Statement to U.S. Congress, House of Representatives, House Armed Services Subcommittee, Special Subcommittee on Oversight and Investigations in Support of the Military Personnel, *Challenges Associated with Achieving Full Dental Readiness in The Reserve Component*, 110th Cong., 2nd sess., April 23, 2008: 2; Timothy K. Jones, "Army Dental Service Support in a Theater of Operations," *U.S. Army Medical Department Journal* PB 8-06-1/2/3, Jan/Feb/Mar (2006): 5.

<sup>12</sup> Marygail K. Brauner, Timothy Jackson, and Elizabeth K. Gyaton, *Medical Readiness of the Reserve Component* (Santa Monica, CA: RAND, Center for Military Health Policy Research, April, 2012), 3.

<sup>13</sup> York, "A Longitudinal Study," 41.

<sup>14</sup> Allen, *Dental Health in the Army Reserves*," 4.

<sup>15</sup> The term “baseline Dental Readiness,” refers to the Selected Reserve Soldier population that is outside of alert for mobilization. Baseline Dental Readiness should not be confused with the Dental Readiness of Soldiers already alerted. Alerted Soldiers have typically undergone additional Dental Readiness preparations—the goal for alerted Soldiers is to achieve full Dental Readiness before reporting to the federal mobilization platform. U.S. DoD: Health Affairs Policy 06-001: Policy on Oral Health and Readiness (Washington, DC, DoD, January 9, 2006), 1.

<sup>16</sup> U.S. DoD, Under Secretary of Defense (Personnel and Readiness), Chu, *Individual Medical Readiness*, 5.4.7.

<sup>17</sup> U.S. Government Accountability Office (GAO), *Army Needs to Assess the Health Status of all Early—Deploying Reservists* (Washington, DC: U.S. GAO, April 2003), 1; Allen, *Dental Health in the Army Reserves*,” 3-5; Patrick Kelley, *Military Medicine: Military Preventive Medicine, Mobilization and Deployment, V. I* (Department of the Army, Office of The Surgeon (OTSG) General, Borden Institute. 2003), 276-277.

<sup>18</sup> Ibid.

<sup>19</sup> During Desert Shield/Storm (1990-91), U.S. Army Europe functioned as a force projection platform. As a general dentist assigned to the 769<sup>th</sup> Medical Detachment (Dental Service) in Augsburg, Germany at that time, the author observed firsthand the negative impact that low Army RC Dental Readiness had on deployment preparations. Many RC Soldiers required “just in time” Dental Readiness care before they transitioned to the Persian Gulf Theater, resulting in lost time—disrupting training and other pre-deployment activities. U.S. Department of the Army, OTSG, Information Paper DASG-HS-DC, Army Selected Reserve Dental Readiness, August 23, 2007.

<sup>20</sup> U.S. GAO, *Army Needs to Assess the Health Status*, 1; Allen, *Dental Health in the Army Reserves*,” 3-5.

<sup>21</sup> Hall, Acting U.S. DoD, Under Secretary of Defense for Personnel and Readiness, *Interim Report to Congress*, 4; Bodenheim, “Army Reserve Components Dental Readiness—A Historical,” 27-28; Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> Title 10, U.S. Code 1074.

<sup>24</sup> U.S. GAO, *Reserve Forces: Army Needs to Finalize an Implementation Plan and Funding Strategy for Sustaining an Operational Reserve Force* (Washington, DC: U.S. GAO, September 2009).

<sup>25</sup> Timothy E. Albertson, James R. Honey, George P. Johnson, and Diedre N. Presley, “Individual Medical Readiness Panel,” briefing slides and questions/answers session, Military Health System (MHS) Conference, Washington, DC, January 30, 2008. Out of five DoD Reserve Service Components, Dental Readiness for the ARNG and USAR remained the most problematic DoD IMR metric; Ibid., 9.

<sup>26</sup> James R. Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance to Establish the Army Selected Reserve Dental Readiness System (ASDRS),” staffing slides for U.S. Department of the Army staffing action, OTSG, U.S. Army Medical Command, Falls Church, VA, April 11, 2008.

<sup>27</sup> In 2007, the Active Army Dental Care System (AADCS) was neither sized, nor authorized (per U.S. Code) to address the Army RC Dental Readiness problem. The comparatively small size of the Army’s AADCS, relative to the enormously large Army Selected Reserve population, was evident when comparing the Army to the Air Force and Navy. Even though each of the three Services had approximately the same number of Active Component (AC) dentists (active duty, government service, and contract)—approximately 1200—supporting their active care systems, the Army Selected Reserve population was nearly two times larger than the Air Force, Navy and Marine Selected Reserve populations combined. This Service difference has remained unchanged since 2007—currently there are approximately: 1) Army: 1,109 dentists; 2) Navy: 1,280 dentists; and 3) Air Force: 1,052 dentists; and the Selected Reserve end strengths have remained at the 2007 levels. The main reason for this large inter-Service AC/RC difference is that the DoD Basis of Allocation for the active dental care systems per Service is based solely on the size of their respective AC population—and not linked to Selected Reserve population size. Historically, this difference is one of the primary reasons that the Army has struggled the most to improve RC Dental Readiness. U.S. DoD, Medical Support Agency (Air Force), Bureau of Medicine & Surgery (Navy Office of the Chief, Dental Corps), and Manpower & ACOR (U.S. Army DENCOM), Manpower Data, Washington, D.C. and San Antonio, TX, April 2012.

<sup>28</sup> U. S. Department of the Army, OTSG, Information Paper DASG-HS-DC, TRICARE Dental Program (TDP) and policies, May 15, 2008.

<sup>29</sup> Gary C. Martin, TRICARE Management Activity (TMA), Statement to U.S. Congress, House of Representatives, House Armed Services Subcommittee, Special Subcommittee on Oversight and Investigations in Support of the Military Personnel, *Challenges Associated with Achieving Full Dental Readiness in The Reserve Component*, 110th Cong., 2nd sess., April 23, 2008.

<sup>30</sup> U.S. Department of the Army, OTSG, Information Paper DASG-HS-DC, Reserve Component Dental Readiness, January 7, 2004.

<sup>31</sup> U.S. GAO, *Army Needs to Assess the Health Status*, 12; Albertson, Honey, and Presley, “Individual Medical Readiness Panel.”

<sup>32</sup> Title 10, U.S. Code 1074a(f).

<sup>33</sup> U. S. Department of the Army, OTSG, Information Paper DASG-HS-DC, Army Selected Reserve (SELRES) Dental Readiness, August 23, 2007; Sproat, Statement to U.S. Congress, *Challenges Associated with Achieving*.

<sup>34</sup> Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides, slides 74 and 73.

<sup>35</sup> U.S. Army Medical Command (MEDCOM) and U.S. Army Training and Doctrine Command (TRADOC), "Expansion of First Term Dental Readiness Program," Memorandum of Understanding (MOU) Between U.S. Army Training and Doctrine Command and U.S. Army Medical Command, Fort Sam Houston, TX, July 9, 2004: 1-4; LTG George W. Casey, Jr., U.S. Army Chief of Staff, "Execute Order 265-09, Soldier First Term Dental Readiness (FTDR)," Washington, DC, August 7, 2009.

<sup>36</sup> U.S. DoD, Under Secretary of Defense for Personnel and Readiness, Unified Legislative Budgeting Initiatives (ULBI), 09A votes, made available to U.S. Department of the Army, OTSG through email from ASA(M&RA), Pentagon, Washington, DC, May 24, 2007.

<sup>37</sup> Ibid.

<sup>38</sup> U.S. Department of the Army, Department of Military Operations (G-3, Contingency Operations) Information Paper, HQDA EXORD 452-06 in Support of Ready Response Reserve Unit (R3U) Pilot Program Overview, December 12, 2006.

<sup>39</sup> A related finding was noted in a 1998 MEDCOM study; it stated: "The RC should not be in the business of providing their own medical readiness support, unless there is a specific and direct training benefit to the provider unit. The basic idea of creating a nationwide medical network within the RC (using organic RC resources) to provide support to RC Soldiers on weekends seems to be marching in the wrong direction. The ability to receive medical support should not be linked to the constantly changing number, strength, and physical locations of RC medical units." U.S. Department of the Army, MEDCOM, Center for Health Education and Studies, *Reserve Component Medical Readiness*, Congressionally directed 746 Study, San Antonio, TX, June 22, 1998, 4.2. Excerpt from conclusion section: 4.2.

<sup>40</sup> U. S. Department of the Army, OTSG, Information Paper DASG-HS-DC, Operational Dental Support, January 29, 2008; Honey, "Funding Requirement in Support of Recommended ASA(M&RA) Guidance," staffing slides.

<sup>41</sup> LTG George W. Casey, Jr., U.S. Army Chief of Staff, "Execute Order 310-08, RC Demobilization Dental Reset (DDR)," Pentagon, Washington, DC, October 8, 2008.

<sup>42</sup> The author assisted writing the interim report to Congress: T.R. Hall, Acting U.S. DoD, Under Secretary of Defense for Personnel and Readiness, *Interim Report to Congress, Reserve Component Dental Readiness*, Report to Chairman, Senate Committee on Armed Service, and Chairman, House Committee on Armed Service, 111th Cong., (Washington, DC: U.S. DoD, April 7, 2009); Honey, "Funding Requirement in Support of Recommended ASA(M&RA) Guidance," staffing slides; James R. Honey, "Proposed Funding Requirement in Support of Army Selected Reserve (SELRES) Dental Readiness," staffing slides for U.S. Department of the Army staffing action, OTSG, U.S. Army Medical Command, Falls Church, VA, August 24, 2007.

<sup>43</sup> Ibid.

<sup>44</sup> Sproat, Statement to U.S. Congress, *Challenges Associated with Achieving*, 2; U.S. GAO, *Reserve Forces: Army Needs to Finalize*, 25.

<sup>45</sup> Hall, Acting U.S. DoD, Under Secretary of Defense for Personnel and Readiness, *Interim Report to Congress*, 4; Honey, "Funding Requirement in Support of Recommended ASA(M&RA) Guidance," staffing slides.

<sup>46</sup> U.S. Army Dental Command (DENCOM), "RC Mobilization Report Sep 2008, FY08, and Historical," Mobilization Data DENCOM compiled and sent to ARNG, USAR, Training and Doctrine Command, Forces Command, and 1st U.S. Army leadership, distributed via email from San Antonio, TX, October 24, 2008; James R. Honey, "Army Selected Reserve Dental Readiness System Capabilities Integration and Trend Analysis," briefing slides with scripted commentary, Army Reserve Forces Policy Committee (ARFPC), Pentagon, Washington, DC, May 19, 2009.

<sup>47</sup> U. S. Department of the Army, OTSG, "Reserve Forces Dental Readiness Integration," informational slides, ARFPC, Pentagon, Washington, DC, April 28, 2008.

<sup>48</sup> James R. Honey, "Update: Army Selected Reserve Dental Readiness Initiative," briefing slides, ARFPC, Pentagon, Washington, DC, January 16, 2008; Albertson, Honey, and Presley, "Individual Medical Readiness Panel."

<sup>49</sup> Honey, "Proposed Funding Requirement in Support of Army Selected Reserve (SELRES) Dental Readiness," staffing slides; Honey, "Funding Requirement in Support of Recommended ASA(M&RA) Guidance," staffing slides.

<sup>50</sup> U.S. Secretary of Defense Robert M. Gates, "Utilization of The Total Force," memorandum for the Secretaries of the Military Departments, Washington, DC, January 19, 2007.

<sup>51</sup> U.S. Army Center for Army Analysis, *Cost Benefit Analysis of Army Initiative 4*, 1.

<sup>52</sup> Honey, "Proposed Funding Requirement in Support of Army Selected Reserve (SELRES) Dental Readiness," staffing slides; Honey, "Funding Requirement in Support of Recommended ASA(M&RA) Guidance," staffing slides; *Ibid.*, 7.

<sup>53</sup> James R. Honey, "ATSG Update: Army Selected Reserve Dental Readiness Initiative," briefing slides, OTSG, Falls Church, VA, September 18, 2007; Honey, "Proposed Funding Requirement in Support of Army Selected Reserve (SELRES) Dental Readiness," staffing slides.

<sup>54</sup> The first sentence of the February 11, 2008 ASA(M&RA) memorandum was crafted to purposefully specify that all Soldiers assigned to Selected Reserve units, if ever called to deploy, would deploy within 75 days after being mobilized; it states: "All Reserve Component (RC) Selected Reserve units of the Army are scheduled for deployment within 75 days after being mobilized." This caused Title 10, U.S. Code 1074a(d) to require the provision of dental exams and DRC 3 treatment for all Selected Reserve Soldiers assigned to Selected Reserve units outside of alert. U.S. Department of the Army, ASA(M&RA), Ronald J. James, "Reserve Component Deployment Readiness Standards" memorandum for Deputy Chief of Staff, G-1, Deputy Chief of Staff, G3/5/7: Chief, Army Reserves, Director, Army National Guard, Commanding General: U. S. Army Forces Command, U.S. Army Training and Doctrine

Command, CF: Assistant Secretary of Defense for Reserve Affairs, Washington, DC: U.S. Department of the Army, February 11, 2008.

<sup>55</sup> Honey, “Proposed Funding Requirement in Support of Army Selected Reserve (SELRES) Dental Readiness,” staffing slides; Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides.

<sup>56</sup> Honey, “Army Selected Reserve Dental Readiness System Capabilities.”

<sup>57</sup> In anticipation of this enhanced dental Critical Requirement (CR), the author—serving as an OTSG dental staff officer supporting Total Force issues at that time—developed cost modeling for ASDRS in 2007, based on a modification of two separate DoD directed Independent Government Cost Estimates (IGCE); these IGCEs were provided by Kennell and Associates, Inc. (March 2004 and February 2006). In August 2007, the author staffed this new modeling construct, which became known as the “Army Modified Kennell,” through DA and RC stakeholders. The Army G-1 Manning (MM) programmers adjusted POM cost drivers for DRC 3 treatment based on the “Army Modified Kennell,” which predicted an initial 27% DRC 3 rate upon examination. Honey, “Proposed Funding Requirement in Support of Army Selected Reserve (SELRES) Dental Readiness,” staffing slides.

<sup>58</sup> Programming for ASDRS funding: DoD uses the Planning, Programming, Budgeting, and Execution (PPBE) process to allocate resources. As part of the PPBE process, Army RC programmers—serving in the DA G-1 MM Program Evaluation Group (PEG)—enter program data into the DA recording database, the PROBE. The PROBE is used to: 1) Record Army programs and budgets. 2) Prepare the Army’s portion of the POM. To input the PROBE, RC programmers use the database-spreadsheet, Requirement Builder (R-Builder), which helps to organize program data into Management Decision Packages (MDEP). Each MDEP has a specific Army Program Element (APE) code. The MDEP APE code for RC Medical and Dental Readiness is NG6H. Once the PEG validates MDEP NG6H requirements (within R-Builder), RC programmers then input those requirements into the PROBE—as a validated Army Critical Requirements (CR). A CR does not represent a funding decision. Rather, the DA G-1 determines how much of the CR will actually get funded (by percentage); this funding decision is then recorded in the PROBE. The ARNG and USAR each have a separate NG6H account that covers dental (ASDRS) and other medical-IMR requirements (excluding medical treatment—since, unlike DRC 3 treatment, U.S. Code does not authorize the use of O&M funds for medical treatment outside of alert). As a separate, but related issue, NG6H funding is not “fenced” (protected from being shifted to other programs); this increases the importance of leader awareness and support for ASDRS programming, funding, and execution.

<sup>59</sup> ASDRS staffing milestones: 1) In September 2007, the Acting the Surgeon General of the Army (ATSG) approved the author’s plans to begin staffing policy guidance to establish an Army Selected Reserve dental support system; 2) On February 12, 2008, after release of the ASA(M&RA) February 11 policy, the author disseminated an enclosure to all U.S. Army stakeholders stating: “The Army has met the criteria in paragraph (1) of subsection Title 10, U.S. Code 1074a (d), which requires the Army to provide Dental Readiness care (limited to dental examinations and DRC 3 treatment) under subparagraphs (C) and (D) for all Selected Reserve members assigned to ARNG and USAR units. This enhanced funding requirement applies to all drilling Selected Reserve Soldiers assigned to Army Selected Reserve units outside of alert for mobilization.” 3) On July 17, 2008, the author completed the staffing for

recommended ASDRS policy guidance (and funding requirement) and forwarded it to ASA(M&RA) for final staffing. This was the culmination of a comprehensive review and staffing process—beginning November 28, 2006. James R. Honey, “ATSG Update: Army Selected Reserve Dental Readiness Initiative,” briefing slides, OTSG, Falls Church, VA, September 18, 2007; Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides.

<sup>60</sup> Beginning in February 2008, the House Armed Services Committee has periodically shown interest and support for ASDRS through numerous official queries and reports. For example, in June 2009, one such report (H. Rept 111-166) stated: “...the committee is aware of an innovative Army effort to systematically address this challenge through the Army Selected Reserve Dental Readiness System. The committee directs the Secretary of the Army to submit a report, to the congressional defense committees, on the status of the Army Selected Reserve Dental Readiness System...”; National Defense Authorization Act For FY 2010, 111th Cong., 1st sess. H. Rept. 111-166. Washington: GPO, Jun 18, 2009, Reserve Dental Readiness, 339; Ibid.

<sup>61</sup> Table 3 was adapted from staffing input the author (while serving as the TRADOC Dental Surgeon) provided for the DENCOM Chief of RC Operations in March 2010 to help update the Army G-1 Personnel Policy Guidance (PPG) and various Army Regulations. Although not included in Table 3 (and not essential for implementing ASDRS), Congress clarified—and reinforced—aspects of the fiscal-legal framework used for ASDRS in the FY09 National Defense Authorization Act (NDAA) by directing the following adjustments to Title 10, U.S. Code 1074a: 1) Adding section (h), which specifies that Operation & Maintenance (O&M) funds of a RC of the armed forces may be available for the purposes of Title 10, U.S. Code 1074a(d) to ensure Dental Readiness. 2) Adding section (g), which authorizes the Secretaries concerned to extend Title 10, U.S. Code 1074a provisions to certain other Service Members (SM) as needed. 3) At Title 10, U.S. Code 10 74a(d)(1), the NDAA removed “Secretary of the Army shall” and replaced it with “Secretary concerned shall,” which authorizes the other Services to implement a program similar to ASDRS if desired. As a separate but related inter-Service item, the May 2008 House Report 110-652 directed: “...the committee directs the Secretary of Defense to review ASDRS in the context of all of the RCs and provide recommendations for further actions to the congressional defense committee ...” Duncan Hunter National Defense Authorization Act for FY 2009, 110th Cong., 2nd sess. H. Rept. 110-652 (Washington: GPO, May 16, 2008), Reserve Component Dental Readiness, 384; Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides.

<sup>62</sup> In June 2007, while serving as an OTSG dental staff officer—supporting Total Force issues, and chairing the Dental All Army Working Group (DAAWG)—the author conducted a DAAWG VTC to solidify plans for an Army Dental Digital Repository (ADDR). The ADDR would collate all compo dental digital systems into a single digital repository. DENCOM agreed to sponsor ADDR and USAR agreed to adopt DENCLASS (previously developed by the ARNG). ARNG and DENCOM also agreed to continue to refine DENCLASS record standardization. U.S. Department of the Army, OTSG, U.S. Army Medical Command, DAAWG VTC “RC Dental Readiness Update,” Falls Church, VA, June 6, 2007.

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.



<sup>65</sup> Alan T. Smith, Director, Information Management (IM), U.S. DoD, Office of the Assistant Secretary of Defense (Health Affairs) (OASD (HA)), interview by author, Falls Church VA, February 15, 2012.

<sup>66</sup> Jeffrey S. Marks and Thomas E. Strohmeyer, "US Army Dental Command Information Management: Poised to Provide Quality Support for the Next 100 Years," U.S. Army Medical Department Journal PB 8-06-1/2/3, no. Jan/Feb/Mar (2011): 50; Ibid.

<sup>67</sup> Ibid.

<sup>68</sup> U.S. Department of the Army, ASA(M&RA) James, memorandum, "Policy Guidance for Establishing," 2.

<sup>69</sup> Reserve Health Readiness Program (RHRP) home page, available at: <http://rhrp.fhpr.osd.mil/home.aspx>, (select component and then select dental) (accessed February 10, 2011); Honey, "Funding Requirement in Support of Recommended ASA(M&RA) Guidance," staffing slides.

<sup>70</sup> U.S. Department of the Army, ASA(M&RA) James, memorandum, "Policy Guidance for Establishing," 2.

<sup>71</sup> Army Reserve Component web site: "My Hooah 4 Health" available at: <http://rhrp.fhpr.osd.mil/home.aspx>, (accessed April 18, 2012).

<sup>72</sup> The ASDRS base program covers all Army Selected Reserve Soldiers outside of alert; it does not, however, cover non-alerted Individual Ready Reserve (IRR) and Inactive Guard (ING) Soldiers. Instead, IRR and ING Soldiers are covered by ASDRS only after being alerted—under Title 10, U.S. Code 1074a(f), primarily using contingency funding rather than base funding. Since the start of the Global War on Terror (2001), IRR and ING mobilizations have been minimal—the total number of unique (by social security number) Soldiers mobilized since FY01 is 31 ING and 17,119 IRR; and for FY12 March-Year To Date (YTD), the total is 12 ING and 1,426 IRR Soldiers. U.S. DoD, Office of the Secretary of Defense (Reserve Affairs), Manpower Data (FY00-FY12 YTD through March), Pentagon, Washington, D.C., March 17, 2012; Headquarters Department of the Army, G-1, Manning Program Evaluation Group (PEG) Brief, "NG6H: Medical Readiness, POM-Budget Estimate Submission (BES) FY14-18 Requirements Brief," briefing slides for Program Budget Review, Army G-1 Manning PEG, Pentagon, Washington, DC, January 5, 2012; Honey, "Army Selected Reserve Dental Readiness System Capabilities."

<sup>73</sup> The Ready Reserve includes: Selected Reserve, IRR, and ING Soldiers.

<sup>74</sup> U.S. Department of the Army, ASA(M&RA) James, memorandum, "Policy Guidance for Establishing," 2-3.

<sup>75</sup> Ibid., 3.

<sup>76</sup> U.S. Army Reserve Command, Dental Surgeon, *Medical Protection System (MEDPROS) Dental Readiness Statistics for USAR*, Fort Bragg, NC, April 17, 2012; ARNG, Dental Surgeon, *MEDPROS, Dental Readiness Statistics*, Washington, D.C., April 17, 2012; U.S. Army

DENCOM, Assistant Chief of Staff for Plans and Operations, *Army RC Dental Readiness Statistics at Federal Mobilization Platforms*, San Antonio, TX, May 11, 2012.

<sup>77</sup> “Dental readiness has a direct, measurable, and immediate impact on qualifying RC Soldiers to deploy and provide operational capabilities across the full spectrum of missions. The better RC dental readiness, the less cross-leveling is likely to occur. Dental readiness also affects BOG time. In effect, improved RC dental readiness is one factor that has dramatically enhanced recent RC readiness.” Kevin J. Vink, Army Reserve Component: Transformation to an Operation Force (Carlisle Barracks, PA: U.S. Army War College, February 20, 2010, 10; Also, contract costs at federal mobilization platforms have declined since FY08 as shown per U.S. Army DENCOM, Assistant Chief of Staff for Contracting Invoices, San Antonio, TX, January 11, 2012; Honey, “Army Selected Reserve Dental Readiness System Capabilities.”

<sup>78</sup> Planning factors used to calculate lost training days are the same as those used to staff ASDRS funding and policy guidance as follows: 1) DRC 3 Soldiers X 2.75 hours to convert DFC 3 to 2, shown in 10 hour duty days (training days). 2) DRC 3 Soldiers X 25% surgical X 1.5 duty days recovery. 3) DRC 3 Soldiers X 2 dental appointments required on average X 2 hours transit for appointments. 4) Unit escort required for each Soldier appointed for surgery: DRC 3 Soldiers X 25% X 3 hours needed for unit escort (2 hours transit and 1 hour for surgery). 5) Total Training Days lost based on DRC 3s as well as NO GOs (using 10 minutes per No Go). Honey, “Army Selected Reserve Dental Readiness System Capabilities”; Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides, slide 63; DENCOM, Assistant Chief of Staff for Plans and Operations, *Army RC Dental Readiness Stats*.

<sup>79</sup> Programmatically, the ASDRS “covered population” consists of all drilling Selected Reserve Soldiers, excluding Active Guard and Reserve (AGR), Initial Entry Training (IET), and those that are considered “non-participating”—approximately 20% of the drilling Selected Reserve cohort (this is a routine planning factor applied to all Army RC programs aimed at the drilling Selected Reserve cohort; it accounts for those Soldiers that are deployed, ETSing, attending IET and other schools, and unavailable for various other reasons). This leaves approximately 367K (142K USAR and 225K ARNG) as the “ASDRS covered” population. This compares to approximately 100K for AGR/IET Soldiers supported by the AADCS. Additionally, the AADCS-DDR “covered population” depends entirely upon contingency OPTEMPO (at the height of Overseas Contingency Operations—since 2008—DDR has supported approximately 60K/year, consisting of 24K for USAR and 36K for ARNG). Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides, slide 19.

<sup>80</sup> U.S. Army MEDCOM and U.S. Army TRADOC, “Expansion of First,” MOU; Casey, Jr., U.S. Army Chief of Staff, “Execute.

<sup>81</sup> Active Duty Dental Program (ADDP) home page, available at: <https://secure.addp-ucci.com/ddpddw/> (accessed February 11, 2011).

<sup>82</sup> As a separate but related issue, the FTDR program is a significant additional DENCOM requirement without additional resources. As evidence of this, the Army’s Dental Treatment Facility (DTF) capacity and the number of dentists—active duty, government service, and contract dentists—is similar to that of both the Navy and the Air Force, yet, in FY11 the Army saw 35% and 53% more patient encounters (in DTFs) than the Navy and Air Force, respectively. This difference in the number of Patients seen/year is at least in part due to the

enhanced FTDR requirement—and to a lesser extent, DDR. It is also important to note that the DoD Basis of Allocation for Army facilities and personnel has not increased for FTDR—and Base Realignment and Closure (BRAC) act of 2005 was not meant to, nor does it, address FTDR (BRAC provided only minor increases in capacity in certain locations, due to increases in “daily weighted student averages”). Also, the DRC 3 treatment needs of IET Soldiers have tended upward according to a 2008 Tri-Service Center for Oral Health Studies (TSCOHS) survey (up 10% from 2000 to 2008). So, DENCOM should consider reassessing the FTDR mission requirements and coordinate with MEDCOM and DoD if needed. Thomas M. Leiendecker, Gary “Chad” Martin, and David L. Moss, “2008 DoD Recruit Oral Health Survey: A Report on Clinical Findings and Treatment Needs,” *Military Medicine*, Supplement to Vol. 176, No 8, August 2011: 11; U.S. DoD, Force Health Protection and Readiness Programs, TMA, FY06-11 Dental Patient Encounter Data by Service, Falls Church, VA, January 2012; Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides.

<sup>83</sup> Despite a vast Army RC Dental Readiness improvement, ARNG and USAR Dental Readiness remain among the lowest IMR measures within the DoD IMR Balanced Scorecard Quarterly Report. Also of note, the RC cohort reviewed by the DoD IMR Scorecard includes: “all those SMs not deployed.” So, RC SMs in IET and AGR status are counted in the DoD IMR Scorecard under statistics for the RC—even though IET and AGR SMs are directly supported by active duty programs, not by RC programs. In contrast, the Army’s Medical Protection System (MEDPROS) does not count AGR within RC Dental Readiness percentages, but does count RC Soldiers attending IET. These two different methods for tabulating RC statistics can be confusing at times for stakeholders. U.S. DoD, Force Health Protection & Readiness, TMA, *DoD Balanced Scorecard Individual Medical Readiness Metrics October 2011*, Fall Church, VA, 21 December 2011.

<sup>84</sup> U.S. DoD, Force Health Protection and Readiness Programs, TMA, RHRP, Data (FY09-FY12 YTD through February), Falls Church, VA, February 8, 2012; Honey, “Funding Requirement in Support of Recommended ASA(M&RA) Guidance,” staffing slides.

<sup>85</sup> Interview with confidential source, January 20, 2012.

<sup>86</sup> U.S. Army Reserve Command, Dental Surgeon and Army National Guard Dental Surgeon, *Latest Medical Protection System (MEDPROS) Dental Readiness Statistics for USAR and ARNG*, Via Emails from Washington, D.C. and Fort Bragg, NC, April 2012.

<sup>87</sup> U.S. DoD, Force Health Protection and Readiness Programs, TMA, RHRP, Data (FY09-FY12 YTD through February), Fall Church, VA, February 8, 2012.

<sup>88</sup> The ASDRS Policy Guidance states: “SRP events in support of Army SELRES dental readiness should rarely be required, as this approach does not support the ‘dental home’ at home station goal.” U.S. Department of the Army, ASA(M&RA) James, memorandum, “Policy Guidance for Establishing,” 2.

<sup>89</sup> U.S. DoD, Force Health Protection and Readiness Programs, TMA, RHRP, Data (FY09-FY12 YTD through February), Fall Church, VA, February 8, 2012.

<sup>90</sup> As a related item, the Assistant Secretary of Defense for Health Affairs, in his March 8, 2012 testimony before the House Appropriations Committee Defense Subcommittee, entitled,

*The Military Health System Overview*, discussed the MHS's Patient-Centered Medical Home (PCMH) initiative, which is a program designed to enable patients to more consistently return to the same provider team for routine care—promoting continuity of care. Similar to the ASDRS “dental home” at home station goal, the PCMH is designed to improve readiness, the patient care experience, and to reduce duplicated services. Dr. Woodson also discussed the National Committee on Quality Assurance (NCQA), an outside agency that the MHS is leveraging to help evaluate the PCMH initiative. This type of enhanced focus on continuity of care and QA could also have some applicability for enhancing ASDRS processes. U.S. Department of the Army, ASA(M&RA) James, memorandum, “Policy Guidance for Establishing,” 2.

<sup>91</sup> In his 2008 testimony to Congress, the ARNG Surgeon emphasized the importance of the ARNG implementing a medical readiness days program to assist command emphasis and Soldier compliance with medical-dental readiness requirements. Sproat, Statement to U.S. Congress, *Challenges Associated with Achieving*, 3.

<sup>92</sup> The USAR implemented a medical-dental readiness day program to put Soldiers on paid orders to attend medical and dental appointments during the week—using Reserve Personnel Army (RPA) appropriations funding. BG Jeffrey S. Buchanan, U. S. Army Reserve Command, Office of the Chief, Army Reserve, “Operational Order 10-098, USARC 2010-2011 Medical Readiness Campaign,” Fort McPherson, GA, June 25, 2010.

<sup>93</sup> In November 2008, DoD strongly endorsed the Commission on the National Guard and Reserve (CNGR) Recommendation 34, which specified that a medical-dental readiness days program is an RC measure that the Services should enact. U.S. Secretary of Defense Robert M. Gates, “Recommendations of the Commission on the National Guard and Reserves,” memorandum for the Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, and others, Washington, DC, November 24, 2008, 8-9.

<sup>94</sup> Ibid.

<sup>95</sup> Ibid., 8.

<sup>96</sup> U.S. Secretary of Defense Robert M. Gates, “Report on the Comprehensive Review of the Future Role of the Reserve Component,” cover memorandum and enclosed report for Director, Cost Assessment and Program Evaluation, Washington, DC, April 27, 2011, 75. The Secretary of Defense also issued a directive to institutionalize the Operational Reserve per U.S. Secretary of Defense Robert M. Gates, DoD Directive 1200.17, *Managing the Reserve Components as an Operational Force*, Washington, DC, October 29, 2008.

<sup>97</sup> U.S. Department of the Army, *Standards of Medical Fitness*, Army Regulation 40-501 (Washington, DC: U.S. Department of the Army, Rapid Action Revision, August 23, 2010), 112 and 114. USAR section 9-3, states that it is the responsibility of RC Soldiers to maintain their Medical and Dental Readiness; ARNG section 10-27 states that commanders will ensure Soldiers meet Medical Readiness requirements prior to attendance of Annual Training (AT). ARNG section 10-22 states: “Any Soldier without a current PHA will not attend Inactive Duty for Training (IDT) or AT.”

<sup>98</sup> Thomas R. Lamont, U.S. Department of the Army, ASA(M&RA), *Transforming the Army's Reserve Components into an Operational Force*, Report to the Department of the Army, Under

Secretary of the Army and Vice Chief of Staff of the U.S. Army, (Washington, DC: U.S. Department of the Army, March 2010), 14.

<sup>99</sup> U.S. Department of the Army, Execute Order 185-11 (Reduction of Non-deployables), Washington, DC, April 22, 2011, 3.

<sup>100</sup> In addition to using the Dental Readiness Information Center (DRIC), leaders should determine the best method for developing and applying social media and smart phone applications for improving RC Dental Readiness—and promoting maximum dental health. LTG Eric B. Schoomaker, U.S. Army Surgeon General, *Soldier Medical Readiness Campaign Plan 2011-2016, Version 1.2* (San Antonio, TX: U.S. Department of the Army, MEDCOM, May 2011), 17-18. Available at: [http://www.armymedicine.army.mil/news/docs/SMR\\_CP\\_Version\\_1.2.pdf](http://www.armymedicine.army.mil/news/docs/SMR_CP_Version_1.2.pdf) (accessed February 11, 2012).

<sup>101</sup> U.S. Army Reserve Command and Army National Guard Surgeons Offices, *Data*, Washington, D.C. and Fort Bragg, NC, January 2012; Ibid.

<sup>102</sup> Ellen P. Embrey, U.S. DoD, Assistant Secretary of Defense (Health Affairs), *Report to Congress, Enhancement of Medical and Dental Readiness of Members of the Armed Forces*, Report to Chairman, Senate Committee on Armed Service; and Chairman, House Committee on Armed Service, 111th Cong., (Washington, DC: U.S. DoD, October 3, 2009), 6.

<sup>103</sup> U.S. Army Reserve Command, Surgeon's Office, *Commander's Tools to Enforce Medical Compliance*, Via Email, Fort Bragg, NC, February 18, 2012.

<sup>104</sup> U.S. Department of the Army, *Army Unit Status Reporting and Force Registration – Consolidated Policies*, Army Regulation 220-1 (Washington, DC: U.S. Department of the Army, April 15, 2010), 43.

<sup>105</sup> U.S. DoD, Force Health Protection and Readiness Programs, TMA, RHRP, Data (FY09-FY12 YTD through February), Fall Church, VA, April 17, 2012.

<sup>106</sup> David L. McGinnis, U.S. DoD, Office of the Assistant Secretary of Defense Principle Deputy, "Impact of Reporting Medical Readiness (MR) Class 4 Indeterminate Status on Army Reserve Component (RC) Dental Readiness," memorandum for ASA(M&RA), Washington, D.C., August 7, 2009.

<sup>107</sup> U.S. Department of the Army, *Army Unit Status Reporting*, 43.

<sup>108</sup> Schoomaker, U.S. Army Surgeon General, *Soldier Medical Readiness Campaign*, 18.

<sup>109</sup> There is a strong DoD precedent for implementing this recommendation. The 2009 DoD report to Congress states: "Some Services use eligibility for annual training to enforce IMR in the RC. The Navy Reserve's sustained and consistent high level of medical and dental readiness is attributed to adherence of its strict policy of no annual training order if medical or dental readiness issues are not addressed. Likewise, the Air Force Reserve Orders Writing System (AROWS) for the Air National Guard and Air Force Reserve codes members who do not meet medical or dental standards, preventing issue of any orders"; Embrey, U.S. DoD, Assistant

Secretary of Defense (Health Affairs), *Report to Congress*, 6; U.S. Department of the Army, Standards of Medical Fitness, 112 and 114.

<sup>110</sup> Buchanan, U. S. Army Reserve Command, Office of the Chief, Army Reserve, “Operational Order.”

<sup>111</sup> The RC has historically used mostly “mass events” to help enforce Soldier IMR compliance. With ASDRS, however, there is now a great opportunity to use “virtual SRPs (Soldier Readiness Programs)” to identify Dental Readiness shortfalls electronically, and then to schedule Soldiers for in-office appointments using the ARNG and USAR Automated Voucher System (AVS)—for both exams and any necessary DRC 3 treatment.

<sup>112</sup> U.S. GAO, *Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs* (Washington, DC: U.S. GAO, February 2011).

<sup>113</sup> Once there is an established MHS IM enterprise solution for dental—as an incremental step towards the Integrated Electronic Health Record (iEHR)—stakeholders should modify the ADDP Statement of Work (SOW) to require electronic capture of dental information. Next, after establishing an iEHR for dental, stakeholders should synchronize all federal dental networks—to include those under ADDP, TDP, federal mobilization platforms, and the DVA—using a standard federal dental SOW that requires federal networks to capture electronic dental information. Stakeholders can accomplish this similar to how the DAAWG collaborated with RHRP to develop SOW requirements to upload ASDRS (DENCLASS-ADDR).

<sup>114</sup> The MHS Office of the Chief Technology Officer (OCTO)—established in July 2010—is the DoD proponent for executing the Federal Enterprise Strategy to achieve the iEHR; the OCTO Chief Technology Officer (CTO) assists stakeholders with developing and moving IM action plans forward. The developing MHS web based open source infrastructure will permit a variety of electronic views and applications. VistA dental application and other applications can, therefore, achieve interoperability with MHS IM, while still retaining their current views and fields. The MHS IM enterprise deployment is also now made less complicated since the infrastructure is converting to a web based format (“cloud computing”). Alluding to these developments in February 2012, the DVA Chief Information Officer (CIO), Mr. Roger Baker, stated, “...the integrated health record system (of the DVA) would eventually reside in the Defense Information Systems Agency’s (DISA) (MHS) cloud computing infrastructure.” Currently, according to Mr. Baker, DISA is working with DVA to stand up VA’s own VistA EHR system in a cloud environment. He went on to note, “Hospitals don’t need to know and shouldn’t care where their VistA system is running.” Mr. Baker’s remarks were at: “Information Week Government” at: <http://www.informationweek.com/news/government/policy/232601159> (accessed April 17, 2012); Smith, Director, Information Management, OASD (HA), interview by author; Mark Goodge, U.S. DoD, MHS, CTO, OCTO, interviewed by author, Falls Church, VA, January 17, 2012.

<sup>115</sup> One of the fundamental Federal Health Information technology principles is: “Build boldly on what works.” U.S. Department of Health and Human Services, Office of the National Coordinator for Health and Information Technology, *Federal Health Information Technology Strategic Plan 2011-2015*, (Washington, DC: U.S. Department Health and Human Services, March 2011), 7.